Washington State Department of Labor & Industries
Workers' Compensation Services

Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 36: Nursing Home and Other Residential Care Services

Effective July 1, 2013

Link: Look for possible **updates and corrections** to these payment policies at:

http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2013/default.asp#3

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Payment policy: All residential care services

When residential services are covered

The insurer covers:

- Proper and necessary residential care services that require **twenty-four hour institutional care** to meet the workers needs, abilities, and safety, *and*
- Medically necessary **hospice care**, comprising of skilled nursing care and custodial care for the workers accepted industrial injury or illness.

Services must be:

- Proper and necessary, *and*
- Required due to an industrial injury or occupational disease, *and*
- Requested by the attending physician, *and*
- Authorized by an L&I ONC or self-insured employer before care begins.

Note: Services provided in adult day care center facilities aren't covered by the insurer.

Prior authorization and reauthorization

Initial admission

Residential care services require prior authorization. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator.

Link: For authorization procedures on a self-insured claim, contact the self-insurer. Contact information is available at: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp.

When care needs change

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for reauthorization of the workers care.

Who must provide these services to qualify for payment

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for twenty-four hour institutional care including:

- Skilled Nursing Facilities (SNF),
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital,
- Critical Access Hospitals (CAHs) licensed by DOH and Veterans Hospitals using swing beds to provide long term care,
- Adult Family Homes,
- Assisted Living Facilities,
- Boarding Homes, *and*
- Hospice care providers.

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.

Note: TCUs must obtain a separate provider number from L&I.

Services that aren't covered

Adult day care center facilities or assisted living facilities performing adult day care services

Services provided in adult day care center facilities aren't covered by the insurer.

Pharmaceuticals and durable medical equipment (DME)

Residential facilities can't bill for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed by a pharmacy or DME supplier.

Note: Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

Requirements for billing

Providers beginning treatment on a workers' compensation claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this chapter.

Link: The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125 (see "Billing procedures").

All residential care services should be billed on form **F245-072-000** ("Statement for Miscellaneous Services").

Link: This form is available at:
http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627

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Additional information: Negotiated payment arrangements

Insurers with existing negotiated arrangements made **prior to January 1, 2005** may continue their current arrangements and continue to use billing code **8902H** until the worker's need for services no longer exists or the worker is transferred to a new facility.

Note: Billing code **8902H** ("Negotiated payment arrangements") is a code that pays "by report."

Additional information: Residential services review, periodic independent nursing evaluations

The insurer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but aren't limited to:

- Onsite review of the worker, *and*
- Review of medical records.

All services rendered to workers are subject to audit by L&I.

Link: For more information, see RCW 51.36.100 and RCW 51.36.110.

Payment policy: Residential services, including boarding homes, assisted living facilities, and adult family homes

Requirements for the Long Term Care Assessment Tool

At the insurers' request, a Long Term Care Assessment Tool must be completed by an independent Registered Nurse (RN):

- Within 10 days of admission, *and*
- At least once per year after the initial assessment.

The tool determines the appropriate L&I payment grouping.

Link: The tool is available at

http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345

Services that can be billed

For dates of service July 1, 2012 or after:

The numeric score determined by the Long Term Care Assessment Tool will determine which billing code to use. The three levels of care will be applied to all nonskilled nursing facility types. The payment rates are daily payment rates (see table below).

Note: Don't bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

If the **assessment score** is…	Then the appropriate **billing code** is:	Which has this **description**:	And a **maximum fee** (daily rate) of:
6 – 20	**8893H**	L&I RF Low	**$164.20**
21 – 36	**8894H**	L&I RF Medium	**$199.38**

37 – 57	**8895H**	L&I RF High	**$234.57**

Payment policy: Critical access hospitals using swing beds for sub acute care

Payment methods

As of July 1, 2011, critical access will be paid for swing bed services utilizing a hospital specific POAC rate.

Prior authorization

You may contact an occupational nurse consultant (ONC) for approval.

Link: To obtain information for contacting an ONC, call L&I's Provider Hotline at **1-800-831-5227**.

Requirements for billing

Upon approval from a Labor and Industries ONC, critical access hospitals should bill their usual and customary charge for sub acute care (swing bed use) on the **UB-04** billing form.

Identify these services in the "Type of Bill" field (Form Locator 04) with 018x series (hospital swing beds).

Link: To view the UB-04 form see

http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1651

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Payment policy: Veterans Administration hospitals using swing beds for sub acute care

Payment methods

Veterans Administration will be paid for swing bed services utilizing a hospital specific POAC rate.

Prior authorization required

Contact an Occupational Nurse Consultant (ONC) for approval.

Requirements for billing

Upon approval from a Labor and Industries ONC, Veterans Administration hospitals should bill their usual and customary charge for sub acute care (swing bed use) on the UB-04 billing form.

Identify these services in the "Type of Bill" field (Form Locator 04) with 018x series (hospital swing beds).

Link: To view the UB-04 form see

http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1651

Does this policy apply to self-insured employers?

No. Self-insured employers' payment formula for hospital inpatient services and non-fee schedule hospital outpatient services = *Your hospital specific POAC factor* **x** *Allowed charges*. Contact your insurer for correct form and payment procedures.

Payment policy: Hospice care

Requirements for billing

Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Hospice programs must bill the following HCPCS codes:

If the **hospice care is provided in**…	Then bill for services using **HCPCS code**:	Which has a **maximum fee** of:
Nursing long term care facility	**Q5003**	**By report**
Skilled nursing facility	**Q5004**	**By report**
Inpatient hospital	**Q5005**	**By report**
Inpatient hospice facility	**Q5006**	**By report**
Long term care facility	**Q5007**	**By report**
Inpatient psychiatric facility	**Q5008**	**By report**
Place “NOS”	**Q5009**	**By report**

Payment limits

Hospice claims are paid on a “by report” basis (see table above).

Occupational, physical, and speech therapies are included in the daily rate and aren’t separately payable.

Payment policy: Skilled nursing facilities

Requirements for the Minimum Data Set Basic Assessment Tracking Form

Within 10 working days of admission, nursing facilities and transitional care units must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker. The completed MDS with the RUG score must be sent to the ONC or SIE/TPA for authorization of the appropriate billing code.

Link: The form is available from CMS at: www.cms.gov/NursingHomeQualityInits/.

This form or similar instrument will also determine the appropriate L&I payment group. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment group to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.

Payment policy: Skilled nursing facility and transitional care unit beds

Payment methods

L&I uses a modified version of the skilled nursing facility (SNF) prospective payment system for developing the residential facility payment rates.

The fee schedule for SNF and transitional care unit (TCU) beds is a series of daily facility payment rates including:

- Room rates,
- Therapies, *and*
- Nursing components depending on the needs of the worker.

Note: Medications aren't included in the L&I rate.

Prior authorization

A modified Resource Utilization Group (RUG) score must be sent to an ONC or SIE/TPA for authorization of the appropriate billing code.

Additional information: Fee schedule, effective July 1, 2013

Billing code	Description	Included Medicare RUG groups	Maximum fee
		Rehab groups:	
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	**$656.95**
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	**$492.15**
8882H	Rehab-High	RHX, RHL, RHC, RHB, RHA	**$458.72**
8883H	Rehab-Medium	RMX, RML, RMC, RMB, RMA	**$424.07**
8884H	Rehab-Low	RLX, RLB, RLA	**$331.33**

Billing code	Description	Included Medicare RUG groups	Maximum fee
		Nursing services groups:	
8885H	Extensive Services	ES3, EES2, ES1	**$410.45**
8886H	Special Care High	HE2, HE1, HD2,HD1, HC2, HC1, HB2, HB1	**$305.74**
8887H	Special Care Low	LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1	**$305.00**
8888H	Clinically Complex	CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1	**$304.06**
8889H	Behavioral Symptoms and Cognitive Performance	BB2, BB1, BA2, BA1	**$222.64**
		Reduced physical function groups:	
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	**$234.57**

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asphttp://www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services	L&I's website: http://feeschedules.Lni.wa.gov
Long Term Care Assessment Tool for completion by an independent RN	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345
Minimum Data Set (MDS) Basic Assessment Tracking Form *or* **Resource Utilization Group Residential Care Services for Injured Workers form**	Medicare's (CMS's) website: www.cms.gov/NursingHomeQualityInits L&I's website: http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2460
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Statement for Miscellaneous Services form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627
Washington revised code (state laws) regarding **audits of healthcare providers**	Revised Code of Washington (RCW) 51.36.100: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.100 RCW 51.36.110: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.110

▸ **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**.